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ABSTRACT

Supportive relationships, especially those with primary caregivers, are crucial for both the physical survival and the healthy social-emotional development of infants and toddlers. This guide, the first in a series on infant mental health from the Center for Program Excellence, describes how supportive relationships promote the social-emotional development of very young children. The guide is written for infant/family program leaders and contains exercises that focus on supervisory issues and on strategies that can be used in working directly with families. The report is presented in the following sections: (1) "What Is Infant Mental Health?" defining the concept of infant mental health; (2) "What's So Important about Good Relationships?" discussing the role of relationships in promoting and supporting children's mental health; (3) "Good Relationships Are Catching," highlighting how strong relationships between supervisors and staff as well as staff and families foster nurturing parent-child relationships and promote infant mental health; (4) "Practical Strategies for Promoting Infant Mental Health," identifying specific steps leaders can take to promote infant mental health at the supervisory and organizational levels; and (5) "Guidelines for Identifying Infant Mental Health Needs," discussing key steps in identifying children who may have specific mental health needs or who may require additional support in developing social-emotional skills. The guide's two appendices present leadership dilemma individual or group activities and brainstorming activities regarding key qualities in building strong relationships. (Contains 25 references and lists 16 additional resources.) (KB)

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BUILDING STRONG FOUNDATIONS:

PRACTICAL GUIDANCE FOR PROMOTING
THE SOCIAL-EMOTIONAL DEVELOPMENT OF
INFANTS AND TODDLERS

The ZERO TO THREE Center for Program Excellence

by Rebecca Parlakian and Nancy L. Seibel, M.Ed., NCC

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The ZERO TO THREE Center for Program Excellence

The Center for Program Excellence (CPE) offers customized training, technical assistance and consultation to infant/family programs. The CPE's services are designed to support program leaders and their staff members in providing the highest quality services to infants, toddlers and their families.

Publications available in the CPE's *Resources for Program Leaders* series are listed below. New titles are added regularly. For information on program consultation and training services, contact us at 202-638-1144 or email cpe@zerotothree.org. For more information about publications, contact 800-899-4301 or orders@zerotothree.org.

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This primer on reflection and relationship-based organizations provides user-friendly definitions and examples of reflective supervision for both direct service staff as well as administrative/support staff. This resource is a comprehensive introduction to both understanding and implementing these important concepts.

The Power of Questions: Building Quality Relationships with Families

Examining the complexities of direct service work with parents and children, this publication explores how leaders and staff alike can use reflective approaches to build quality partnerships with families.

Being in Charge: Reflective Leadership in Infant/Family Programs

This publication discusses a number of leadership issues, including: how to individualize one's relationships with staff members, encourage collegial work, and learn from conflict. Specifically, it describes how leaders can use self-awareness, observation, and flexible responses as tools to manage stress and increase on-the-job effectiveness.

Reflective Supervision in Practice: Stories from the Field

Reflective Supervision in Practice follows the experiences of four infant/family programs as they implement reflective supervision, an approach that is characterized by mutual respect, collaboration, and open communication between supervisors and staff. Challenges and benefits of the change are addressed. Discussion questions and suggested activities are provided to facilitate both individual and group learning.

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Building Strong Foundations:

Practical Guidance for Promoting the Social-Emotional Development of Infants and Toddlers

by Rebecca Parlakian and
Nancy L. Seibel, M.Ed., NCC
ZERO TO THREE
Washington, D.C.

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Introduction

[Relationships] created in the earliest years are believed to differ from later relationships in that they are formative and constitute a basic structure within which all meaningful development unfolds.... When young children and their caregivers are tuned into one another, and when caregivers can read the child's emotional cues and respond appropriately to his or her needs in a timely fashion, their interactions tend to be successful and the relationship is likely to support [the child's] healthy development in multiple domains, including communication, cognition, social-emotional competence, and moral understanding. (National Research Council and Institute of Medicine, 2000, pp. 27-28)

Relationships with family, friends, and colleagues enrich our lives in countless ways, help support us in difficult times, and provide us with encouragement and strength. Relationships also can present challenges and, at times, be difficult or hurtful.

For infants and toddlers, supportive relationships — especially those with primary caregivers — are crucial both for physical survival and for healthy social-emotional development. Very young children, like adults, find that nurturing connections with others provide the loving context necessary to comfort, protect, and encourage. Relationships can offer children a buffer during stressful or lonely periods. And, as with adults, very young children can experience relationships that are filled with fear, pain, and insecurity. Through relationships with the important adults in their lives, infants and toddlers develop mental health, or social-emotional wellness, which includes the ability to form satisfying connections with others, play, communicate, learn, and experience the full spectrum of human emotions. For very young children, these interactions with primary caregivers are the fundamental way they come to know the world and their place in it.

This publication discusses the different strategies that program leaders can use to promote infant mental health. Three key skills — observation, self-awareness, and flexible response — are crucial for supporting the social-emotional development of infants and toddlers. Observation helps leaders and staff members learn from the children

and parents with whom they work and allows better understanding of the meaning of others' behavior. Self-awareness helps program leaders and staff recognize and learn from their own experiences and reactions. Flexible responses help leaders and staff individualize services based on babies' and parents' needs, temperaments, and personal histories. These skills, which can be used in all infant/family disciplines, promote children's mental health through the formation of supportive, nurturing relationships between leaders and staff, staff and parents, and parents and children.

All infant/family programs function differently. In some, leaders may be more directly involved with providing services to parents and children while in others, directors may support and supervise the staff who provide services. This resource, written for both types of leaders, includes exercises that focus on supervisory issues and on strategies that can be used in working directly with families.

As the first in a series of publications on infant mental health from the Center for Program Excellence, *Building Strong Foundations* provides readers with a thorough grounding in how supportive relationships promote the social-emotional development of very young children. The material is divided into the following sections:

- **What Is Infant Mental Health?**, which defines the concept of infant mental health.
- **What's So Important About Good Relationships?**, which discusses the role of relationships in promoting and supporting children's mental health.
- **Good Relationships Are Catching**, which highlights how strong relationships between supervisors and staff as well as staff and families foster nurturing parent-child relationships and promote infant mental health.
- **Practical Strategies for Promoting Infant Mental Health**, which identifies specific steps leaders can take to promote infant mental health at the supervisory and organizational levels.
- **Guidelines for Identifying Infant Mental**

SKILLS TO PROMOTE INFANT MENTAL HEALTH

Observation: A two-part process: first, carefully noting what one sees and hears; second, drawing inferences about the possible meaning of others' behavior, tone of voice, body language, or reactions.

Self-Awareness: The ability to examine and learn from one's own reactions, thoughts, and feelings about the work.

Flexible Response: Approaching others in a way that reflects their individual needs, temperament, and strengths.

Health Needs, which discusses the three key steps in identifying children who may have specific mental health needs or who may require additional support in developing social-emotional skills.

What Is Infant Mental Health?

When we hear the phrase “mental health,” what often comes to mind is “mental illness.” The way we are using the term *mental health* in this publication is synonymous with healthy social and emotional development in very young children. All infants and toddlers need and deserve a solid foundation of mental health to develop, learn, and grow.

It is well established, however, that infants and toddlers can experience a full spectrum of social-emotional functioning, ranging from mental health — an ability to form satisfying relationships with others, play, communicate, learn, and experience the range of human emotions — to disorders of very early childhood. One way to conceptualize infant mental health is to focus on this continuum of experience by differentiating services into three levels of increasing intensity:

“Infants and toddlers depend heavily on adults to help them experience, regulate, and express emotions.”

- **Promotion**—encouraging good mental health and social-emotional wellness;
- **Prevention**—preventing the occurrence or escalation of mental health problems and minimizing children's social-emotional developmental risk—usually a family-centered process; and,
- **Treatment**—providing intensive services designed to address a child's mental health needs and support his or her return to positive developmental progress—usually a family-centered process.

Although these categories can overlap and no sharp boundaries exist among them, they do provide

a useful framework for thinking about the level and intensity of services that programs may offer. The following questions can guide this thinking:

- Which infant mental health services is your program structured to provide?
- What services do you wish your program was providing or was more skilled at providing?
- What are some examples of the ways your staff support children's social-emotional development?

ZERO TO THREE's definition of infant mental health expands on the concepts introduced above and emphasizes the key competencies that contribute to children's social-emotional wellness (ZERO TO THREE Infant Mental Health Task Force, 2001):

Infant mental health is the developing capacity of the child from birth to 3 to: experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn – all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development.

The meaning of this definition is illustrated through the following scenarios:

- The phrase **developing capacity** is a reminder of the extraordinarily rapid pace of growth and change in the first 3 years of life.

“When Kyle was first born, it was just diaper changes and feedings. But now, at 4 months, he's all personality. He smiles and plays with me. He loves bright colors. And I swear he has a favorite lullaby. I mean, he's a real person!”

Here, Kyle is showing his emerging ability to engage and interact with others.

- Infants and toddlers depend heavily on adults to help them **experience, regulate, and express emotions**.

“I've been trying to help Shyla, age 2, stop biting when she gets angry. We kept talking about how to ‘use your words’ to show you're upset. And then yesterday at play group, Ben grabbed a toy out of her hand. She turned to me and

said, 'Mama, no, no!' And then she started to cry...but she didn't bite. I just gave her a big hug and told her how proud I was. Then we made our way over to Ben and talked about sharing the toys."

Here, Shyla is showing her growing skill at substituting words for actions, and regulating her emotions in appropriate ways.

- Through close, nurturing interpersonal relationships with parents and other caregivers, infants and toddlers learn what people expect of them and what they can expect of other people.

Jayson, 18 months old, was on a walk with his father when he became frightened of a neighbor's dog barking from behind a fence. "Hey buddy, what's wrong? Is Champy making too much noise?" Jayson turned and ran a few steps back to his father who scooped him up in a hug. "Champy startled me, too. I guess he must be feeling a little grumpy today, huh?"

Here, Jayson is learning that, when he becomes uncertain and fearful, other people — like his father — will be there to support him. His father's sensitive response contributes to Jayson's growing sense of security, trust, and self-esteem.

- The drive to **explore and master one's environment** is inborn in humans. Infants' and toddlers' active participation in their own learning and development is an important aspect of their mental health.

Kara, 2 months old, was mesmerized by the red rattle in front of her. She closely followed the apple-red ball with her eyes as her mother moved it from side to side. When her mother brought it closer to Kara, she reached her hand out to grasp it. "Do you want the rattle, Kara? Here you go," her mother said, passing the toy to Kara to hold.

Kara shows how even very young infants use their senses to learn more about the world.

- The context of **family and community** is where infants and toddlers learn to share and communicate their feelings and experiences with significant caregivers and other children. A



PHOTO CREDIT: ©MARILYN NOLT

developing sense of oneself as a competent, effective, and valued individual is an important aspect of infant mental health.

Molly, 18 months old, and her father went out one Saturday to do a few errands. At the bakery, a woman held the door for the two of them: "Aren't you just adorable in that hat?" she said, remarking on Molly's new baseball cap. As Molly's father was placing his order for a dozen bagels, the man behind the counter asked whether Molly could have a cookie. "How about we get two cookies — one for each us?" said her dad. While they sat outside and enjoyed their snack, a passerby smiled and said, "The two of you sure look like you're having fun this afternoon."

Community support has a positive effect on the parent-child relationship and on Molly's understanding of herself as a valued individual.

- **Culture** influences every aspect of human development, including how infant mental health is understood, adults' goals and expectations for

young children's development, and the child-rearing practices used by parents and caregivers.

Midori, age 3, sat down to eat dinner with her family. Her mother placed a short pair of child-sized chopsticks into her hands and allowed her to practice feeding herself. Her mother then fed Midori and even bunched some sticky rice into a ball for her to eat with her hands.

Although the food and utensils may be different from other families' traditions, Midori is experiencing social interaction as well as physical and emotional nurturing during mealtime.

How Your Program Already Supports Infant Mental Health

One challenge for leaders is to recognize the different ways in which their programs are already supporting infant mental health. This means assessing the program environment (or the context in which children learn and grow), as well as the way in which staff members interact with children. In general, programs that provide relationship-based, family-centered services are also supporting children's healthy social-emotional development.

A developing sense of oneself as a competent, effective, and valued individual is an important aspect of infant mental health.

Leaders can first begin to gauge programmatic commitment to children's mental health through careful observations. Are services designed to promote social-emotional development, prevent the occurrence or escalation of problems, intervene or treat identified mental health needs? Does the environment (layout, furniture, room organization, and other elements) support a calm, nurturing feeling in the program? Do staff members and families seem to enjoy their time together? Do their interactions feel comfortable, unforced? Observations like these give leaders clues about how the program is promoting the good mental health of everyone involved in services — staff, children, and parents alike.

In practice, direct-service staff can enhance children's mental health by providing families with the opportunity to learn and grow within supportive, collaborative relationships. This translates to:

- providing families and other important caregivers with the skills and information they need to support children's social-emotional development;
- providing parents with empathy and guidance as they work to resolve conflicts or challenges related to their children or family;
- respecting the strengths of individual family members and the family as a whole;
- being respectful of and open to learning about families' cultures and beliefs;
- identifying early signs of emotional or behavioral concerns; and
- promoting successful partnerships among families, infant/toddler professionals, and community support systems (*The Florida State University Center for Prevention and Early Intervention Policy, 2000*).

All staff members — not just direct-service professionals — help to create an environment that promotes social-emotional well-being. The following observations highlight the effect that everyday interactions can make in supporting children's mental health.

8:25 a.m. — A mother entered the child-care center, holding the hand of a crying toddler. The mother looked harried, and the child was clearly distraught. Once inside the foyer, the child stopped and refused to walk forward. His mother began pushing him gently (and then not so gently) on the back to get him moving. "I don't want you to go," the little boy said. His mother took a deep breath and said, "Well, I have to go. I'll be back tonight, just like I always am."

At Child Care Center A: The center's receptionist was engaged in some computer work. She looked up with a sigh and a slightly irritated expression at the child, who was now screaming and sobbing. The mother caught her eye, but neither spoke, and the mother and child continued to the boy's classroom.

At Child Care Center B: The center's receptionist glanced up from her work. She smiled at the mother, saying "At this age, it can be

really hard to say good-bye. I see it happen all the time. I guess your little boy just loves having you around, doesn't he?" The mother smiled and visibly relaxed. "And I love having him around, too. It's tough to say good-bye, isn't it, kiddo?" Her son stopped crying as his mother reached around to give him a hug. The receptionist got up and knelt in front of the boy: "You know, Miss Patti was just telling me this morning that she got a new story book and put it on the shelf for the children. Maybe you and Mom can go and see if it's there before Mom goes to work."

What do parents and children experience in these environments? What effect do interactions like these have on social-emotional development or children's mental health?

To support children's and parents' mental health, both leaders and staff members can think about the importance of their interactions with families. Even very small actions, like those described above, have a real effect on the parent's and child's experience as well as on parent-child relationships. It is important for everyone in the program to understand this, because relationships — especially relationships with parents — are the primary context for learning during a child's first years of life.

In the second example above, the staff member was able to respond to the individual needs of both parent and child as well as support their shared relationship. For the mother, the staff member helped to defuse a potentially awkward and embarrassing situation. Also, and just as importantly, she reframed the child's behavior to highlight what he might be feeling or trying to communicate to his mother. For the child, the staff member responded to his need to be noticed and supported during a difficult transition. By meeting the needs of both parent and child as individuals, this staff member helped mother and son resolve the immediate conflict at hand as well as to understand and enjoy one another in a new way.

Infants and toddlers can also form meaningful relationships with the other important adults in their lives: extended family members, caregivers, and medical and other direct-service professionals. These people, too, can provide a context for learning, support, nurturing, and protection. By using skills of observation, self-awareness, and flexible response, staff members are able to play an important role in supporting children's social-emotional

growth. (See Appendix A, "Leadership Dilemmas: What Would You Do?" on page 23 for an additional exercise on this topic.) The promotion of infant mental health can and does occur across disciplines, emphasizing not only the work but also how the work is done.

55 Relationships – especially relationships with parents – are the primary context for learning during a child's first years of life. 99

A Look at Social-Emotional Development

Although observation is the first step to promoting infant mental health, information that is gathered through observation must be placed in the context of what is known about the typical social-emotional development of very young children. We can think about how infant mental health develops and is promoted through the first years of life in many different ways. The model presented in Table 1 (page 6) is based on the writing of Stanley Greenspan, M.D., and examines the evolution of intelligence and social-emotional competency in the context of infants' and toddlers' relationships with their parents and other important adults. This model emphasizes how all development — and especially social-emotional development — emerges over time and through interactions with others. Although a larger discussion of this issue is outside the scope of the publication, readers may refer to the books by Brazelton (1992), Greenspan (1999), Lieberman (1993), Segal (1995a, b and c), and Pruett (1996) cited in the references section.

What's So Important About Good Relationships?

All children are born wired to form relationships. In fact, establishing a close, nurturing bond with a primary caregiver is a major developmental task for infants and toddlers and one that is fundamental to future development. This process of relationship building begins in pregnancy, continuing

TABLE 1: GREENSPAN'S SIX ESSENTIAL DEVELOPMENTAL STAGES

Developmental Goal	Age Range	What's Happening?
Stage One: Being calm and interested in all the sensations of the world	Approximately birth to 3 months	The baby is • learning how to be calm, regulated, secure, and interested in the world around him or her • trying to organize the information he or she is receiving from his or her senses
Stage Two: Falling in love	Beginning at approximately 2 to 4 months, roughly spanning the period from "first smiles to crawling"	The baby is • becoming more focused on parents and other people and things outside him- or herself • expressing emotional reactions of his or her own (e.g., smiles and frowns) • expressing pleasure in others' company
Stage Three: Becoming an intentional two-way communicator	Approximately 3 to 10 months	The baby is • purposefully using gestures (facial expressions, actions, and sounds) to communicate • responding to others' gestures with gestures of his or her own • realizing that his or her expressions elicit a response from parents and caregivers and that what he or she expresses can and does have an effect
Stage Four: Learning to interact to solve problems and discover a sense of self	Approximately 9 to 18 months	The baby is • learning to solve problems • learning to see and decipher patterns • communicating in increasingly complex ways • learning what to expect from others, based on interactions and experiences with parents and caregivers • developing a sense of self
Stage Five: Creating ideas	Approximately 16 to 36 months	The child is • becoming skilled in symbolic thought (e.g., labeling images with words) • using verbal means to communicate needs and desires • engaging in pretend play • learning to recognize and communicate his or her feelings • learning to understand others' feelings
Stage Six: Building bridges between ideas	Approximately 36 to 48 months	The child is • sharing his or her own ideas; exchanging ideas with parents and caregivers • learning to be logical, connecting one idea to another in a meaningful way • developing a sense of time • developing a sense of space, or "near" and "far" • making connections between ideas that convey feelings (e.g., asking "Why are you sad?")

Note. From *Building Healthy Minds: The Six Experiences that Create Intelligence and Emotional Growth in Babies and Young Children* (pp. 380-381), by Stanley Greenspan with Nancy Breslau Lewis, 1999, Cambridge, MA: Perseus Books. Copyright 1999 Stanley I. Greenspan. Adapted with permission from author.

throughout the infant's first 12 months and, indeed, his or her entire life.

Research shows that supportive relationships have a tangible and long-term influence on children's healthy development, contributing to optimal social, emotional, and cognitive development for infants and toddlers (Zeanah & Doyle Zeanah, 2001). As a child grows, supportive relationships with parents and caregivers shape his or her self-image and provide the child with the resilience he or she needs to face new challenges. In addition, nurturing, sensitive adult-child interactions are crucial for the development of trust, empathy, compassion, generosity, and a conscience. These relationships are far reaching; research has shown that they provide a context for supporting the development of children's curiosity, self-direction, persistence, cooperation, caring, and conflict resolution skills (Greenough, Emde, Gunnar, Massinga, & Shonkoff, 2001). For older children, healthy maternal-child relationships are a precursor of school readiness (Kaplan-Sanoff, 2000). Throughout the life span, nurturing and supportive relationship experiences provide a model for loving relationships.

What Do Children Need to Promote Their Healthy Social-Emotional Development?

The research cited above reminds practitioners that families are the primary context within which children's learning and growth takes place. Although the effectiveness of infant/family programs is often measured by improvements in babies' development and well-being, these successes tend to involve more fundamental changes in the entire family system. The following list (adapted from National Research Council and Institute of Medicine, 2000) provides a sketch of what types of interactions typically characterize supportive and nurturing bonds between parent and child or between caregiver and child. Although determining what each of these components may look like in your program will take some effort, learning to recognize signs of healthy, positive relationships is as important as recognizing signs of relationship disorders.

Take a few moments each week to observe interactions between staff members and children as well as between parents and children at your program. Which of these interactions do you observe?

- Responsive care that contributes to the child's developing self-confidence



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- Affection and nurturing that contributes to the child's developing self-esteem
- Protection from harms that children fear and threats of which they may be unaware
- Opportunities to experience and resolve human conflict cooperatively
- Support provided for the development of new skills and capabilities
- Exchanges through which children learn the give-and-take of satisfying relationships with others
- The experience of being respected by others and of respecting them as human beings
- Good social support provided to all members of the family
- Respect for a child's home culture through its sensitive integration with services

Recognizing the Complexity of Families

Each baby is born into a unique family that has its own culture and history, its own strengths, and

TABLE 2: QUESTIONS TO ASK WHEN THINKING ABOUT PARENTS' AND CHILDREN'S BEHAVIOR

Information About the Child:

- What is the behavior the staff member or the parent has observed? (Keep in mind that parents and staff members may have different perspectives and experiences. It is important to consider information from all involved when interpreting the observations.)
- What is the child's developmental age? What behaviors might be expected at this age? Does the behavior that caused concern fall into the range of normal behavior?
- Is the child's behavior explained by individual differences or temperament styles?
- Is the child's behavior explained by a need for new skills and knowledge?
- Is the child's behavior explained by attempts to get emotional needs satisfied?

Information About Important Relationships in the Child's Life:

- What is the child's relationship like with his or her primary caregiver or other important family member?
- Describe the network of relationships surrounding the child. Could the child's behavior be a response to or reflection of these relationships?
- Is the child's behavior explained as a reaction to a primary caregiver's (or other's) mental health needs?

Information About the Child's Context:

- Does the behavior take place in multiple contexts, for example, both in the program and at home?
- Is the child's behavior explained by conditions of his or her environment?
- Could the child's behavior be explained by a medical condition?

Information About the Parent's History and Experiences:

- How might the child's behavior reflect one or more of the following issues?
- What is the quality of the parent's relationship with his or her own parents?
- What is the quality of the parents' relationship with each another?
- Does the child resemble a family member that the parent has strong feelings about (positive or negative)?
- Is the parent experiencing (or had she/he experienced) mental illness or substance abuse problems?
- Has the parent experienced past pregnancy losses, either by accident or by choice?

Adapted from Ohio Association of Infant Mental Health and the Infant Mental Health Movement in Ohio, 2000 and U.S. Department of Health and Human Services, 1996.

its own ways of coping with stress and adversity. Infants' and toddlers' growth and development takes place in the context of these nuclear and extended family relationships. Parents' different ways of interacting with their babies are shaped by the nature of the parental relationship, and their own experiences of childhood. The varying degrees of confidence, excitement, anxiety, and sensitivity that mothers and fathers bring to parenting are powerfully influenced by their relationships with their own mothers and fathers.

Parents' ability to support their children's social-emotional development is also affected by the degree to which they are in contact with extended family and friends as well as by the extent to which this network is able to provide practical help and emotional support. Parents who receive strong support from family and significant friends have the resources that enable them to respond to their baby's social-emotional needs. Those who are cut off from sources of emotional support and hands-on help may find that their isolation contributes to their stress level and makes meeting their baby's needs difficult or overwhelming.

A third family influence on infant mental health is the general level of stress the family is facing and the family's capacity to adapt to this stress. Ideally, families will be able to continue to meet individual members' social, emotional, and physical needs — even during periods of change and upheaval (and the period surrounding the birth of a child is a period of stress and change for all families!). When more stress is affecting the family than parents are able to manage, parents' capacity to provide their infant or toddler with sensitive, responsive care may be diminished.

Babies and toddlers, young as they are, also influence relationships in the family system. Babies come into the world with their own style of reacting to and participating in the world around them. The parent of a baby who experiences long spells of inconsolable crying, who is awake through the night, or who always wants to be held has a very different experience than the parent of a new baby who quickly settles into a predictable nap and feeding schedule and whose crying is infrequent and easily soothed. These variations in personality and temperament greatly affect interactions that the baby experiences with parents and primary caregivers as well as the quality of these growing relationships.

Premature babies and babies with special needs present unique challenges for parents and require

both short- and long-term adaptations to the family system as a whole. The period of adjustment that immediately follows a diagnosis can be a stressful one for families, and this stress may never completely abate; parents can find that advocating for their child continues through infancy and toddlerhood and well into his or her school years. In some cases, parents are so consumed by meeting their children's immediate physical needs that promoting social-emotional development becomes a secondary concern. For these families, especially, staff members must listen and sensitively respond to the stresses, stories, and histories shared by parents. When parents feel their emotional needs are being met, they are more capable of doing the same for their children.

Direct-service professionals who are able to focus on both the child's and the parent's needs are better able to support the development of the family as a whole. "Questions to Ask When Thinking About Parents' and Children's Behavior" (see Table 2) highlights just a few of variables that can affect parent's and children's behavior and relationships. Can you think of families in your program who were affected by any of these issues?

Thinking About Culture

Anjali, who recently moved to the United States from India, was asked by a neighbor to baby-sit her 7-month-old daughter, Hannah, one evening. When Anjali arrived at the house, Hannah was in her crib upstairs. Her parents told Anjali, "She's still settling down.... She might cry a little until she falls asleep, but don't worry. She usually drifts off in about 10 or 15 minutes." Even though Hannah did seem to fall asleep quickly, Anjali spent the evening pacing nervously in front of the cracked door of her room. What kind of parents let their baby sleep in an upstairs bedroom, all alone? In Anjali's culture, babies and toddlers slept in the same room with their parents where it was easy to hear their cries, comfort them, and hold them.

This issue — how and where an infant should sleep — is just one of many child-rearing practices that can vary tremendously from culture to culture. In fact, one of the most powerful influences on social-emotional development is culture,

STAFF EXERCISE: USING WHAT YOU KNOW ABOUT INFANTS, TODDLERS, AND RELATIONSHIPS

This exercise, designed for use with staff members, builds on the idea of careful observation as a tool to help direct-service professionals learn more about the families' strengths, needs, and goals.

Observation: Ask staff members to think about a family they work with.

- Describe the strengths they see in this family and the strengths of each individual member (including the child).
- Describe some typical interactions between parents, between the parent and child, and between siblings.
- Describe any challenges the family is facing.
- Describe the family's goals in participating in the program.

Self-Awareness: Ask staff members to think back to an encounter they have had with this family. What did this interaction teach them about

- their own feelings with respect to the family or specific members? Their reactions to the family? Their assumptions with respect to the family?
- the family's relationships with one another?
- the family's relationships with them?
- their cultural experience related to the issue raised in this interaction (e.g., imagine how this situation might have been dealt with in their own family)?

Flexible Response: Ask staff members to think about an issue or challenge the family is currently facing. Keeping their observations and experiences in mind, ask them to brainstorm several responses or interventions that would honor the family's individual needs, build on the family's strengths, and support its development.

or the shared beliefs, values, and goals of a group of people (Kalyanpur & Harry, 1999). The effect of culture is considerable, influencing many aspects of family functioning:

- **Child-rearing practices** — *In one culture, a newborn baby is praised for being "adorable," "beautiful," and "perfect." These compliments are a way of welcoming the baby into the family and community. In another culture, this same baby would be called "ugly" to protect it from evil spirits. How do the family's child-rearing practices reflect its cultural beliefs?*
- **Family roles** — *In one culture, an expectant mother and her husband may attend a breastfeeding class together. In another culture, breastfeeding is the exclusive domain of women, and it would cause embarrassment or discomfort if a man were present. What are the family's beliefs about male and female roles in parenting? What is the role of extended family members (e.g., grandparents) in rearing the child?*

STAFF EXERCISE: THINKING ABOUT HOW CULTURE INFLUENCES DEVELOPMENT

Pose the following questions to five different people. There are no right or wrong answers. Your job is simply to listen. Are their responses shaped by culture? In what ways?

- Where should a newborn sleep?
- How should parents respond to a 2-year-old girl who has just fallen down and burst into tears? A 2-year-old boy?
- At what age should toilet training begin?
- What role does extended family play in rearing children?

- **Perception of stresses and supports** — *In one culture, a new mother perceives it as stressful to have her mother-in-law stop by for several hours each day after the birth of her child. In another culture, a mother-in-law might move in with the new family after the birth, and this behavior is experienced as loving and supportive. What is perceived as stressful to the family? What is perceived as supportive?*
- **Perception of "normal" development** — *In one culture, learning to walk is valued because it is believed to be an important milestone of motor*

development and a sign of a child's growing independence. Children's early walking skills are promoted through exercises and games. In another culture, very young children are carried almost constantly, and walking skills are not emphasized. How might cultural beliefs be affecting the family's (or the staff member's) perception of "normal" developmental progress?

- **Meaning attributed to children's behavior** — *In one culture, a crying baby is thought to have colic. In another, it is assumed that he has been given the evil eye. What does the child's behavior mean in the context of his or her family's beliefs?*

It is critical to balance a family or community's cultural legacy with the reality that, even within one culture, a vast range of experiences and beliefs exists. To truly provide "culturally competent" services, leaders and staff members alike can make an effort to learn more about a particular family's history, traditions, and values. This effort requires great skill — openness, collaboration, and flexibility — from staff members and a supportive supervisory framework that helps staff members to learn from and appropriately respond to families' feedback.

Culture also influences staff-family relationships in the way that services are delivered. Work in the infant-toddler field is, at its heart, an ongoing interaction between cultures: that of the staff member and that of the family. In addition to their national or ethnic cultures, staff members bring the perspective of their professional culture (Kalyanpur & Harry, 1999). That is, their approach to working with families may be defined in large part by the beliefs of their field and by their training, education, and experience. This professional perspective can affect the staff member's perception of the "correct" or "appropriate" response to a child's needs.

Learning more about each family's traditions, beliefs, and histories is necessary if program services are to be truly individualized. Leaders can help in this effort by supporting staff members as they identify ways in which families' home cultures can be integrated into children's services, daily routines, and intervention plans.

Good Relationships Are Catching

Providing supportive relationships to others is easier when you experience them yourself. The way in which the positive or negative characteristics of

one relationship are repeated in another is referred to as a parallel process, and this process works at multiple levels in the organization. When leaders establish warm, encouraging relationships with their staff members, then staff members are better able to create a supportive and welcoming environment for parents. Parents, then, are better able to develop and strengthen the skills necessary to provide their children with the nurturing relationships within which they can learn and grow (Parlakian & Seibel, 2001).

Nevertheless, infant-family practitioners rarely receive formal training in how best to establish, maintain, and strengthen relationships. Like all skills, effective relationship building must be learned, practiced, and experienced in order to be used successfully on the job. The supervisory relationship provides the opportunity to develop these skills in what is, ideally, a supportive, nonjudgmental environment. The following vignettes provide examples of how supervisors can, in very subtle and basic ways, encourage or discourage relationship-based work. (See Table 3: Relationship-Based Work in Infant/Family Programs, for a discussion of relationship-based work.)

Vignette 1. Karen, a home visitor who has been on the job for 6 months, is meeting with her supervisor, Lee, for their weekly check-in.

Lee: So, how are things going? Did you meet your visit quota this week?

Karen: Actually, no. I had planned to get a

few more visits in, but when I met with Jana and little Andrew on Tuesday I got thrown off. Jana's boyfriend had been by...and he beat her pretty badly this time. And I didn't really know what to do. I mean, they were fine last week and then by Monday everything was different. So I met with her a few times this week to talk about — you know, her boyfriend. She was really scared, and her face...it was all bruised. A lot worse than before.

Lee: Well, that sounds really difficult for you. And it's important to help out the family. But our visit ratio is important, too, Karen. Our program is designed to help parents and children build closer relationships. We're not domestic abuse counselors. We just aren't in a position to be everything to everyone, as much as we'd like to be. I understand that Jana needed you this week, but we're accountable to our funder if we don't make our visits...you know that. (pause) So is everything worked out with Jana now?

Karen: Oh, we talked about what to do a few times this week. She kept asking me to come back. On Friday morning, she decided she wanted to talk to the police about what happened, and she asked me to go with her. That was the first time I've ever been to a police station. It was noisy...

Lee: So she filed a complaint? It sounds like everything is back on track then.

TABLE 3: RELATIONSHIP-BASED WORK IN INFANT/FAMILY PROGRAMS

Relationship-based work describes an organizational culture in which supportive, respectful relationships — between supervisors and staff, staff and families, and parents and children — form the foundation for the work that is done.

Typically, organizations promoting relationship-based work value the following practices:

- Collaboration, or a commitment to providing services cooperatively with parents and colleagues
- Ongoing growth and change, or learning from experience
- Reflection, or examining one's own thoughts and reactions to the work
- Respect for individuals, or accepting others for their strengths and vulnerabilities
- Sensitivity to context, or a recognition that the environment influences the individual and vice versa
- Open communication, or a belief in the value of other's thoughts and ideas
- Established standards for staff members, or a commitment to professional excellence

Adapted from Bertacchi (1996)

Vignette 2. Jason is a child-care worker who has been working for the last 4 months in an inclusive child-care center. He is meeting with Carol, his supervisor, for their weekly check-in.

Carol: So, how are things going?

Jason: *(sigh)* Okay.

Carol: *(smiles)* Just okay?

Jason: *(returns the smile)* I guess it's just that this job is a lot harder than I thought it would be.

Carol: What are you finding difficult about it? Can we do anything to help you?

Jason: It's not the job itself, I guess. It's more how I feel about things. *(pause)* Like yesterday when the toddler group was dancing to the music we had on? I looked at Toby [a little boy with spina bifida] and felt so bummed that he couldn't dance, too. I don't know, maybe I'm overreacting or something, but he just looked like he wanted to...and I felt really bad about it.

Carol: What you just described makes me think of how it feels to be left out. I know that feeling, and I imagine you do, too. And with Toby — well, I think all of us have had times when we really empathize with a child with a disability and feel very sad about what they may not be able to do. But what I try to do when I feel that way is think about what they can do and what creative ways there are to help them get the experience they're after. How did you know Toby wanted to dance?

Jason: He was smiling really wide. And he was moving his head in time with the music and tapping his fingers. I guess he was dancing in his own way.

Carol: Great observations! It's wonderful that you saw all that. Next time, how can you act on those cues to give Toby the chance to dance with the group?

Jason: *(thinking)* I could help him into the center of the room so he's with everyone else. And maybe I could dance with him. The kids like to follow me around sometimes, so if I'm with Toby, that's where a lot of the kids will be, too.

Carol: Sounds like a plan! Let me know how it works out. Toby is lucky to have a teacher who pays such careful attention.

As you consider Vignettes 1 and 2, think about the following questions:

- In Vignette 1, what aspects of the conversation did the supervisor handle well? Could she have improved her approach? If yes, what could she have done differently?
- As you consider the interactions that the two supervisors had with these staff members, describe the type of relationship that each supervisor is encouraging her staff member to provide to families.
- In Vignette 2, how is Carol, the supervisor, supporting Jason's use of observation, self-awareness, and flexible response as strategies to serve the children in his care?
- How might the experience that Karen has with her supervisor in Vignette 1 affect her relationship with the mother, Jana? How might the experience that Jason has with his supervisor in Vignette 2 affect his relationship with the toddler, Toby? (See Appendix B—For Reflection: Key Qualities in Building Strong Relationships).

Practical Strategies for Promoting Infant Mental Health

Everyone involved in an infant-family program — from van drivers to receptionists to cafeteria workers to direct service staff — can use their daily interactions with children and families to promote infant mental health. Leaders make an especially important contribution, as they have an impact on staff, parents, and children through both supervisory practices and organizational decisions. Listed below are specific suggestions and strategies for leaders, all of which encourage the creation of an environment that supports infant mental health.

Supervisory Strategies

Supervisors, and their programs and agencies, can incorporate the following strategies that support staff in effectively addressing the social-emotional needs of very young children and their families

Provide staff with regular supervision. Supervision that is focused on learning from work with families, that is supportive, and that occurs on a reliable schedule is a valuable opportunity for staff skill development. Supervisory meetings are useful opportunities to introduce and apply skills in observation, self-awareness, and flexible response. This regular contact is also a vital component in supporting staff members as they manage the stress and emotional intensity of working with families.

What You Can Do:

- Learn more about supportive supervisory practices. Attend conferences, speak with colleagues in the field, and read up on the subject (see Emde, Bertacchi, & Mann, 2001; Parlakian, 2001a and b; Parlakian & Seibel, 2001; and Pawl, 2000).
- Begin by establishing regular staff meetings that include opportunities for staff development and peer mentoring (e.g., that encourage staff members to share their experiences and questions about families in the program).
- Schedule regular meetings with individual staff members to discuss the work and the staff member's questions, concerns, and experiences with it.

Promote strengths-based practices.

Strengths-based practices begin with leaders. What do staff members do well? What aspects of the program work especially well? By helping staff members identify what works well in a particular family, practitioners can reinforce and remind parents of their own skill and competency with their child. These strengths become a starting point for future learning and change.

What You Can Do:

- With each supervisee, establish an individual development plan that builds on their strengths and that identifies training and other growth opportunities for specific areas of development.
- Ask staff to identify the strengths of the children and parents on their caseload or in their classroom; use these strengths as a basis for discussing family growth and development.
- With your supervisor, a colleague, or a mentor, reflect on the program's strengths and how these may be used as a springboard to provide higher-quality services to families.

Encourage family-centered services.

Parents should be involved in identifying goals for their family. This collaboration is the most basic component involved in honoring parents' expertise and knowledge about their own child. Working to understand the parent's perspective when he or she makes suggestions related to services is crucial to establishing a satisfying partnership where parents and provider "share the care" of the child. Although you may face times when establishing consensus is difficult or when parents' and providers' goals and expecta-



tions differ, both parent and practitioner must "agree to something ... to accomplish something" (Pawl, 2000, p. 5).

What You Can Do:

- In supervisory sessions with staff members, ask about the family's stated goals and objectives for services.
- Involve families in the program's activities in a range of ways. As examples, you could establish a parent position on your board of directors, invite parents to participate on curriculum and program administration committees, or conduct parent surveys to gauge their level of satisfaction with services.
- Provide training to staff on how to involve parents in delivering services in the home. Although many staff members join programs prepared to provide direct services, few possess expertise in teaching parents to work with their children. This skill is vital if the program is truly committed to family-centered services.

Model flexible responses with staff. In order to individualize their responses, leaders must

know something about their staff: their history, interests, temperaments, and personalities. This information helps leaders respond in ways that respect the unique strengths and needs of their various team members. By extension, when staff members experience these individualized and flexible responses, they are able to incorporate that style into their own interactions with families.

What You Can Do:

- Get to know staff members both professionally and personally.
- Use your own skills in observation and self-awareness to identify appropriately individualized responses to staff members' needs, questions, and concerns.
- Check in occasionally with staff members to ask how they feel the supervisory relationship is working, what they appreciate, and what they may like to change.

Providing supportive relationships to others is easier when you experience them yourself.

Encourage staff's support of inclusion goals for children in your program. Like all children, children with special needs develop within the context of relationships. Developmental challenges, then, rarely sort neatly into the categories of "early intervention" and "infant mental health." The emotional and physical aspects interact and influence one another in a continuous manner across a child's development. Staff must be open to learning about each child, and to individualizing their own responses so both the child and the family have an opportunity to grow in all areas of development — including social-emotional, physical, and cognitive.

What You Can Do:

- Ask about the child and parents as individuals. What are each person's hopes, wants, needs? What is each parent's goals for the development of his or her child and family? What strengths and challenges are observed for each

person? Which of these can be used as a foundation for ongoing learning and growth?

- Involve staff from other related fields (e.g., occupational therapy, early intervention, mental health) to participate in these discussions and share their knowledge.
- Actively seek out opportunities to build staff skills in the area of inclusion by inviting speakers from local universities or nonprofit organizations or by asking a parent to speak about his or her child's experiences in an inclusive program.

Wonder about the development of both child and family. Change takes place in the context of family relationships. Improvements in the child's development often occur simultaneously with growth in the family system. When supervisors encourage discussion about family members' individual strengths and needs, staff is better able to provide both parents and children with more meaningful interventions and more flexible responses.

What You Can Do:

- Present case discussions in staff meetings by asking one or two staff members to discuss a family with whom they are working, including the family's strengths, challenges, and possible next steps.
- Differentiate between child and family development in supervisory discussions, exploring goals and progress for each.
- Ask staff to speak from the viewpoint of both parent and child to explore how their needs may differ.

Focus on multidisciplinary work. Early childhood work is, by its very nature, multidisciplinary; staff members from a range of fields partner to support families' growth and development. This process of thinking both within and beyond one's discipline is challenging and requires training and support. As leaders encourage collegial work among staff members, they also can identify opportunities for all staff members to benefit from the learning that occurs when multidisciplinary teams unite to work with a particular family.

What You Can Do:

- Establish multidisciplinary service teams to meet the diverse needs of families. Occasionally, debrief with staff members to discuss which aspects of team functioning are working well and which are not.

- In supervision, identify instances in which staff members may wish to seek out expert perspectives from other fields: "It's true that Jaden may prefer quieter play, but I'm wondering whether Kate [a child development specialist] might be able to help us clarify whether it's an issue of preference or perhaps a developmental delay."
- Encourage all staff members to think about how they promote a child's mental health through their work. Ask questions like "How do you see your work helping this child develop new social-emotional skills?" and "How might your relationship with this parent and child support their growth as a family?"
- Your local Part C (early intervention for infants and toddlers) program can be a good source of information and support for children with special needs.

Reexamine the relevance of current job descriptions and performance evaluations.

These internal tools should accurately assess and encourage the skills believed most critical for work and should be revisited on a regular basis to ensure that they continue to reflect the program's goals and values. Mechanisms should also be put in place to monitor the long-term development of staff members (e.g., individualized training plans).

What You Can Do:

- Identify broad skills that all staff members in the program should possess (e.g., skills that focus on relationship-based and family-centered approaches). Ensure that these skills are represented in both job descriptions and performance evaluations.
- Conduct annual performance evaluations, and discuss individual development goals with staff members on a twice-yearly basis (preferably, a quarterly basis).
- Provide training to the entire staff — direct-service, support, and administrative staff members — on how they, as individuals, can promote children's social-emotional development. Recognize when staff members do so, and revisit these concepts in supervision.

Recruit staff members who are skilled in infant mental health and children's social-emotional development. Although the task is challenging, leaders can make recruiting staff members with infant mental health expertise a priority when assembling their program's professional team. Having access to professionals with experi-

ence in assessing children's social-emotional needs pays dividends in the quality of services provided to families and in the support offered to the staff (Weatherston, 2000). A position for a person with this expertise can be designed in a number of ways:

- a full- or part-time staff position on-site;
- an internship for a university student placed with the program; or
- as a shared position (or consultant) with other infant-family programs in the area.

Also critical is a program-wide commitment to recruit culturally diverse staff members for all positions involving infant mental health roles to ensure high-quality services for families and communities.

THINKING ABOUT RECRUITING STAFF MEMBERS

The following advertisements are for the same job: a family support worker in a program that supports the healthy development of children from birth to 3 years and their families.

Advertisement #1

Family support worker needed to help families at risk. Organizational, problem-solving, and people skills necessary. Limited travel required; we are a center-based program.

Advertisement #2

Family support worker needed to support parent and child development and to guide family skill building. Teamwork, organization, and listening a must. Reliable transportation required. Local travel; visits take place in family homes.

What You Can Do:

- Begin a dialogue with area programs to gauge their interest in and desire for access to staff members with expertise in infant mental health; propose co-funding this position.
- Lobby local funders and policymakers to sup-

- port regional infant mental health services.
- Partner with university programs to help train students in the social-emotional development of very young children.

Refer when appropriate. Whether in child care or home visits, early intervention or family support, situations inevitably arise when a parent's or child's needs exceed the reach of the staff member, the program, or both. Recognizing these limits is an important and necessary practice that honors the family's need. Making an appropriately timed referral serves the family because it helps family

members to receive the level of intervention they require. At the same time, it also serves the professional who may be feeling stressed, vulnerable, powerless, or frustrated.

What You Can Do:

- At intake, clarify the program's scope of services to families, and explain how the referral process works if additional services are required.
- Use supervision as a tool to gauge when staff may be beginning to feel overwhelmed in meeting a particular family's needs.
- Discuss with the staff how and when to refer.

STAFF EXERCISE: THINKING ABOUT THE MEANING OF CHILDREN'S BEHAVIOR

Situation: Joseph is a 2-year-old who has, until recently, exhibited typical development patterns. He and his mother are participating in a home-based family support program.

Questions to Ask Staff Members

What are you seeing and hearing?

What might the child be feeling?

How does the parent or caregiver respond?

What might be contributing to the child's behavior?

What are some different ways to respond?

What alternative responses or interventions could you suggest based on what you know about Joseph?

Observations and Inferences

• Joseph resists adults, avoids holding and cuddling, and has difficulty with group play.

- Anger, hostility
- Fear
- Feeling as though his needs are not being met

- Confusion
- Hurt feelings when child pulls away from cuddling or embraces
- Concern
- Occasional frustration

- Child's temperament is not being recognized
- Child is experiencing sensory overload
- Child is hypersensitive to types of touch or sound
- Child experiences another feeling before anger (e.g., helplessness, shame)
- Child feels overcontrolled

- First, talk to the parent about the child's personality and needs.
- Learn more about his temperament through observation and talks with colleagues and supervisor.
- Then, try reducing sensory stimuli during the day to prevent the child from feeling overwhelmed.
- Observe for another month and see whether this intervention seems to help. If not, review observations with the parent to revise hypothesis. Develop new action plan.

Note: From *Managing Challenging Behaviors in Infants and Toddlers* by Donna Wittmer and Patricia Franco, 2001, Washington, DC: Presentation at the 5th Annual Head Start and Child Care Birth to Three Institute. Adapted with permission.

Ensure that staff members understand the range of services available to families in your area and how to help families access these services.

Emphasize the importance of observation skills. Observation, the practice of focusing on the behavior, rituals, and daily give-and-take in the parent-child relationship, is one of the most valuable tools in infant-family work. It enables staff members to capture meaning from interactions between parent and child, staff member and child, staff member and family as well as between children (Emde, Bertacchi, & Mann, 2001). Observation provides staff members with the information they need to better understand the family and, thus, to provide more flexible and individualized responses to them.

What You Can Do:

- Provide training for staff members that helps them to distinguish between observation and inference (see "What's the Difference: Observations and Inferences?" on page 18).
- In supervision, ask what staff observed while working with a particular family, what inferences they drew from their observations, and how they plan to respond.
- Share your own observations with supervisees and clarify what they may be feeling or experiencing: "Just now, you sounded a little disappointed that Mr. Chan hasn't come in to the center for a Just Dads night. Is that how you're feeling?"

Enhance staff members' capacity for self-awareness. Leaders can help staff use their own

reactions as a starting point to learn more about the parent, child, and family. Inherent in using one's self-awareness in this way is maintaining an appropriate distance. This process of establishing boundaries, or limits to the professional relationship, is difficult because it sometimes challenges staff's perceptions of their role. Nevertheless, it is a crucial professional skill. Helping staff members learn how to be emotionally present and responsive to families without becoming emotionally involved is an important goal of supervision. Differences in background, however, can affect how issues like boundaries are perceived. Even within the same ethnic and cultural groups, variation in beliefs will likely occur. Leaders must explore how a particular practice or policy is interpreted by the individual staff member, and staff members must do the same for families. See "What Would You Do?" below for an exercise addressing family culture and boundary setting.

Seek to understand the meaning of behavior. Encourage staff to wonder about the meaning of families' experiences and reactions. Within the context of a parent's and child's developing relationship, try to help supervisees understand how each individual in the family system might feel from the inside, not just how a particular behavior looks from the outside. Supervisors can ask "What might this interaction feel like for the baby? For the parent?" The question-based model shown in Table 2 (page 8) helps place children's behavior in a larger context and may be a useful tool for leaders in facilitating supervisory or staff meetings.

WHAT WOULD YOU DO? SPOTLIGHT ON FAMILY CULTURE AND BOUNDARY SETTING

An infant-family program in a large urban area served a number of Russian immigrant families. In that culture, it is considered polite to offer a gift — a bouquet of flowers — to professionals providing services or assistance. The infant-family program, however, has a policy that does not allow staff members to accept gifts from parents on their caseload. This policy causes some hurt feelings among families because, in their culture, gift giving was not seen as seeking favors but merely as being polite.

- How do you think the "no gifts" policy affects staff-parent relationships among Russian immigrant families?
- If you were the program leader, how would you respond to this issue?
- What are the benefits and drawbacks of the solution you propose?
- How would you communicate your proposed solution to the staff? To families?

All behavior has meaning, and trying to identify the possible meanings behind perplexing behavior is doubly important when working with infants and toddlers who may not have the ability to communicate their needs through language. Ultimately, staff members select responses and interventions based on a "best educated guess" of what they think a child's behavior might mean. It is important for everyone involved to continue observing the child to determine whether this initial hypothesis is correct. Potentially, a wide range of explanations could apply to each set of behaviors that a child displays, so staff members should be prepared to modify their responses if further observation and information indicates the need.

WHAT'S FOR DIFFERENCE? OBSERVATIONS AND INFERENCES

Observations refer to what you have seen; they involve a simple reporting of a child's behavior or interactions without any particular meaning or interpretation attached: for example, Miles threw the truck.

Inferences refer to an educated guess about what a child's behavior or interactions might mean: for example, Miles is feeling angry and frustrated or Miles is copying the older children who are playing baseball.

Guidelines for Identifying Infant Mental Health Needs

A common question raised by many program leaders and direct-service professionals is "When should I worry about a child?" This question can be difficult to answer because the normal development of infants and toddlers often encompasses a wide range of skill levels and behaviors. Early development is not always a smooth, consistent path but may, quite normally, become a bumpy road. Occasionally, a child's skills may regress whereas, at other times, they may take quick jumps forward. Practitioners, then, should carefully examine their initial concerns to distinguish any possible infant mental health problems from the wide range of normal variations in infant behavior (Zeanah & Doyle Zeanah, 2001).

When to Consider Referring a Child for Infant Mental Health Services

Generally, most infant mental health practitioners agree that children's behavior should be explored further if it:

- is unusual for the child or causes parents and other caregivers to perceive the child as "difficult;"
- makes satisfying interactions with others difficult;
- is observed in multiple settings by multiple people; and
- persists over time.

In addition, direct-service professionals must keep in mind that culture (the professional's or a family's) can affect one's perception of what is normal development or appropriate parenting. For this reason, caregivers must observe and understand children's behavior in the context of the child's home culture. A solid grounding in infant-toddler development paired with sensitivity to and knowledge of a family's culture should guide staff members' information-gathering efforts. The following three-step process provides some suggestions for comparing normative development with the possibility that an infant or toddler may be experiencing a more serious need.

Step One: Observe the Child

To begin exploring a particular child's mental health needs, one or more staff members must know the child. Much can be done at the program level to develop a richer understanding of individual children's strengths and areas of vulnerability. In particular, staff members can take the following steps:

- raise their questions or concerns about a child with their supervisor;
- arrange for a colleague, supervisor, or mental health consultant to observe the child either in the center or at home;
- observe the child in multiple contexts (e.g., with parents and with other caregivers, in the classroom, on the playground, and during unstructured and structured time);
- determine whether a physical assessment might be useful for the child because medical or biological conditions (e.g., hearing loss, infection, etc.) can cause some "red flag" behaviors; and
- speak to the family to identify the appropriate next steps.

What Does it Mean to "Observe Children"?

Leaders and staff members observe when they carefully watch and listen as children are alone, as they play with peers, and as they spend time

with parents and other caregivers (Meisels, 1996). When observing children, it is important that the observer not infer or assume the meaning of a particular behavior or interaction. Observations simply refer to *what one has seen* — the actions or interactions themselves with no particular meaning attributed to them (also see, "What's the Difference: Observations and Inferences," page 18). Specific areas to observe that provide rich information about children's social-emotional capabilities include the following:

- the way a child handles transitions (e.g., drop-off, pickup, transitions between activities such as from napping to waking);
- individual strengths or vulnerabilities that may be exhibited;
- timing or patterns of behaviors or reactions (e.g., consistently needy and whiney behavior right before lunch);
- ways in which culture may be affecting the child's experience of the program or services;
- usual communication or interaction style (e.g., extrovert, introvert);
- temperament (e.g., easygoing, feisty, slow to warm up);
- developmental progress, with special attention to any seeming regression or loss of previously acquired abilities; and
- "unusual" behavior — behaviors that do not seem to "match" what you know of the child, changes in behavior, or behaviors that concern you, confuse you, or make you feel uncomfortable.

What Can Be Learned From Observations?

After leaders and staff observe, they can begin to think about what the child's behavior might mean. They can use their observations, their experience, and their knowledge as tools to help formulate this *inference*. An inference, otherwise known as an "educated guess" or "hypothesis," is not absolute. Staff and leaders can test their inferences by interacting with the child in a different way or by changing some aspect of the environment in the hopes of better supporting his or her needs. If, over time, these modifications do not elicit a positive change in the child's behavior and interactions, then the practitioner will once again need to observe the child and develop an alternative hypothesis. Sometimes it will take repeated tries to find the "right" response. This trial-and-error process is normal. Observations and inferences are an art, not a science.



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Maddie, a withdrawn 18-month-old, prefers quiet play on her own. When staff members try to engage her in group play and motor activities, she is just as likely to bite her caregivers as to join in. Staff are at their wit's end, convinced Maddie is spoiled and headstrong.

Note that, in the example above, as in life, determining whether a child's actions represent a normative behavior problem or a mental health need is sometimes difficult. In some cases, the problem can be normative. At other times, however, the very symptoms that are perplexing (and vexing) to adults can be an attempt by infants and toddlers to communicate distress. Very young children often lack the language necessary to explain their feelings and needs; instead, they communicate through behavior and patterns of interactions. "Questions to Ask When Thinking About Parents' and Children's Behavior," on page 8, can be used with staff to explore whether a child may be trying to communicate a mental health need. Discussion of these issues helps to put staff observations in the context of the child's individual temperament and development, family and culture, and any relevant external systems (e.g., child care, early intervention services). Supervisory and staff meetings are often useful venues in which to discuss these issues



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and to help staff think more analytically about their experiences and feelings in relation to a particular child and family.

Step 2: Use Self-Awareness as a Tool for Talking With Parents About Your Observations

Those responsible for discussing observations with parents should also wonder about the parent's perceived meaning of the child's behavior. Parents' current and past experiences shape the perceptions they have of their baby and their relationship with him or her; thus, practitioners need to wonder about the meaning behind a child's behavior both from the child's perspective and from the parent's interpretation of it. For example, does the parent experience the expressions of a toddler's need for independence as rejecting or disobedient behavior and, if yes, why? When staff members are aware of their own reactions to a family and sensitive to parent-child dynamics, then their discussions with parents about their children's needs will likely be clear while also respectful and inclusive. Nevertheless, these conversations can evoke strong reactions in parents, sometimes making them feel vulnerable or defensive. In these situations, the use

of value-neutral phrasing that focuses on observed behaviors and interactions (e.g., "I notice ..." or "I've seen ..." or "It seems as though ...") is helpful. Another important practice is for staff members to reinforce parents' expert role by asking what they know about their children's behavior or have themselves observed. To prepare for these conversations, staff members can find it useful to explore their own feelings about a child and family; rehearsing the conversation with a supervisor or colleagues offers them this opportunity (for further discussion of staff-parent interactions, see Pawl & Dombro, 2000, pp. 11-21). The exercise below provides an example of how social-emotional issues may be introduced with parents.

Jackie, a child-care professional, is meeting with Kira, the mother of an energetic 2-year-old named Sammi. Sammi has been at the center in Jackie's group for 3 months. She is in care from 7:30 a.m. to 7:30 p.m. while her mother works at two jobs. From ages 6 months to 1 year, Sammi lived with her grandmother while her mother was in a residential drug treatment facility. She was reunited with her mother soon after her first birthday, but the family moved frequently until settling in an apartment near the center.

Jackie: *Thanks for coming in this afternoon. I know it's not easy to leave work early.*

Kira: *Well, luckily I switched and got the early shift today so I only had to ask for an hour off.*

Jackie: *I'm glad it worked out for you. I appreciate the effort you made to come in today. I wanted to talk with you about how Sammi is doing here at the center. She's really bright and easygoing. And she's such a funny kid! She makes us laugh all the time. There is one thing, though, that I wanted to ask you about. Over the last couple of weeks, I've noticed that sometimes she hurts herself — you know, bangs her head or pinches her arm. I've watched her and it seems to happen pretty consistently when she gets frustrated. I'm not sure what it means, and I thought I should talk with you about it. Have you seen behavior like that at home?*

Kira: *Sometimes I notice it — but I don't pay too much attention. She can't get everything she wants. Like a couple of days ago,*

Sammi had a cookie after dinner, but she wanted another one. If she thinks that banging her head is going to get me to change my mind, she's got the wrong idea.

Direct-service professionals may feel a range of emotions in the course of a discussion like the one above. Being aware of one's own reactions and recognizing the multiple layers at work in these relationships (staff-parent and parent-child) helps practitioners respond effectively. Reread the dialogue above, and think about how you might answer the following questions:

- What are some possible reasons for Sammi's behavior?
- How do you think Kira interprets Sammi's behavior?
- How did Kira's last statement make you feel? What was your reaction to it?
- What would be your response to Kira's last statement?

Step 3: Identify Flexible Responses That Meet the Child's and Family's Needs

Parents and staff members can devise a multitude of responses to meet a child's needs. These can include deciding to observe the child further; restructuring an aspect of the program (e.g., allowing Carly, a very active 1-year-old, to read and play quietly rather than nap with the rest of the children); or referring the child and family for additional, more intensive services. In any case, the need for well-planned follow-up highlights the importance of close collaboration between parents and staff.

Flexible responses mean that each child is seen as a unique individual with his or her own temperament, feelings, and way of experiencing the world. The interventions identified to meet a child's needs are the product of a coordinated effort between parents and professionals in which they try to understand the possible meaning behind the child's behavior — the needs he or she is trying to communicate both verbally and nonverbally. Flexible responses acknowledge the expert role of the family, the strengths and needs of the child, and the skills of the program staff. When behavior arises that is a concern, it is important for everyone involved in the child's life to focus their efforts on how best to meet the child's individual needs. Supervisors play an important role in this process by encouraging staff to bring what they have

observed and learned to discussions with parents and by placing equal value on parents' experiences. Some specific issues to explore in these planning discussions are addressed in the following questions (adapted from Wittmer & Franco, 2001):

- What strategies, approaches, or coping mechanisms do parents and caregivers currently use to respond to the child's needs? Which work best? What new approaches do they want to try?
- In what ways could caregivers or parents change the way they interact with the child to better support him or her?
- What changes could be made to the home or program that would better support the child?
- What assistance, supports, or services do parents and primary caregivers need to better support the child?

In relation to Sammi (see the vignette on pages 20), many possible hypotheses could explain her behavior. Perhaps you can think of several yourself. After discussing the questions above, Jackie (Sammi's caregiver) and Kira (Sammi's mother)

Each important member of the child's life — parent, caregiver, family member, and staff member — adds a thread to this great structure of history, emotion, and experience.

decided that Sammi might be feeling very frustrated because of a language delay that was apparent when Sammi's language was compared to that of other children in her age group. They hypothesized that she may be expressing this frustration as anger toward herself. As a result of their discussion, both Jackie and Kira agreed to take the following steps:

- refer Sammi for a speech-language evaluation;
- refer Sammi for a hearing test;
- read and talk more with Sammi at home and at school; and
- encourage interactive, verbal play in both environments.

Conclusion

Meeting children's social-emotional needs is a core component of all programs serving young children and their families, not just those programs that are ostensibly designed to provide mental health services. This important work begins with program leaders. Leaders can use their own skills in observation, self-awareness, and flexible response as tools to support staff members' relationships with families. In doing so, they are contributing to social-emotional growth and development at all levels of the organization. Infant-family programs are, in essence, a web of relationships in which the child is at the center. Each important member of the child's life — parent, caregiver, family member, and staff member — adds a thread to this great structure of history, emotion, and experience. Together, they have the power to support and sustain, teach and nurture, encourage and assist.

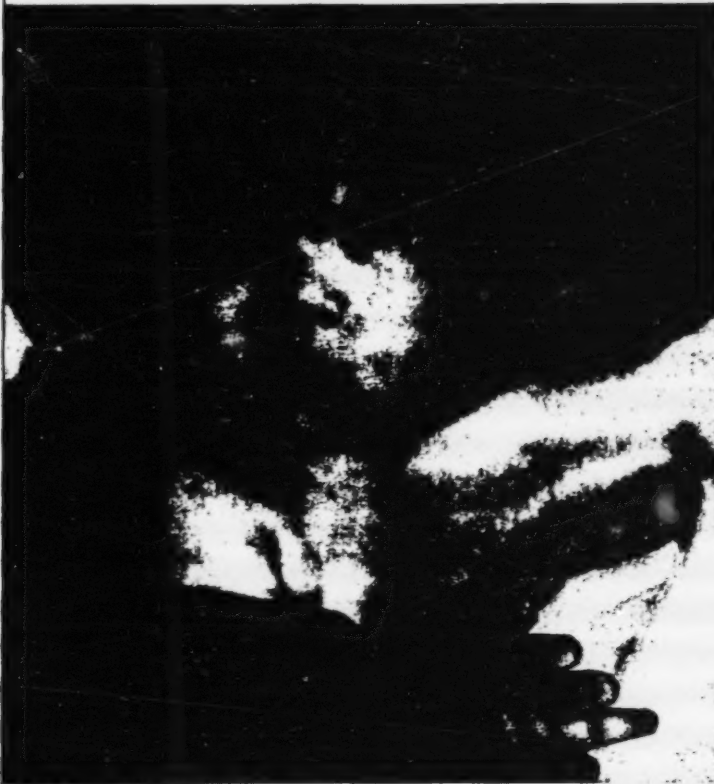


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If the hearing test and speech-language evaluation come back normal, however, Jackie and Kira have agreed to look for other possible explanations for Sammi's behavior.

Also, Jackie, noticing Kira's frustration and impatience, asked how things were going for her. She learned that Kira is under a great deal of stress because of impending lay-offs at one of her places of employment. Jackie reminded Kira that the center's funding agency provides short-term counseling to parents should she want to talk more about her feelings and stresses.

When concluding discussions with parents, staff members should confirm agreed-on next steps and outline the timeline of activities and interventions that will follow before the next meeting. The next meeting date also should be scheduled at this time. If the child is to be referred for assessment, staff members should explain the purpose of the recommended assessment¹, how the assessment will be structured¹, and how the child's performance will be evaluated¹.

¹Because assessment is a larger and more complex issue than is possible to address in this publication, interested readers are referred to Greenspan & Mesets (1996) for more information.

Appendix A. Leadership Dilemmas: What Would You Do?

Self or Group Activity

Following are three challenging situations faced by program leaders in the infant-family field. As you read through each one, ask yourself the following questions:

- How does this situation make me feel?
- How might each participant in these vignettes be feeling? How might they be experiencing the situation presented here?
- What is my best guess (inference) of what is happening here?
- What more would I want or need to know before responding?
- What would I do?

Promotion: Dilemma One — Sharon is the coordinator of a child-abuse prevention program. As an incentive for parents to attend evening educational seminars, the program offers supervised child care. Sharon popped in to observe the child-care room one evening and saw several staff members chatting while two toddlers fought over the room's only toy train. "Quit it, you two," said one of the caregivers, as she walked over, took the train, and placed it on a shelf where neither child could reach it. "They never stop, do they?" she said, as she returned to her colleagues.

Prevention: Dilemma Two — Nathan is the director of a home-visiting program that provides occupational therapy, nursing services, and child development guidance to families with children who have special needs. Carly, a child development specialist, has shared some concerns that arose after her first visit to a family in the program: "I don't know for sure, but from what I observed in today's meeting, I think the mother may be depressed. She looked really withdrawn and sad, lying there on the couch. I asked how she was doing and she said 'not so good.' When I asked her how long she'd been feeling that way, she said it had been a long time." This news was a surprise to Nathan. The family had been receiving occupational therapy services from Sally-Anne for the last 2 months. When he asked Sally-Anne about it, she said, "Yes, the mom has seemed really down. But I didn't want to ask. It felt like prying when I was

supposed to be there to work with Randy [a 10-month-old with cerebral palsy]."

Treatment: Dilemma Three — Bo is a community mental health consultant who has been hired to assist a local child-care center in determining how best to meet the needs of Kaylee, a 2-year-old with autism. Kaylee's parents are frustrated: "The staff here are not helping Kaylee make new friends. Whenever we come in, she's doing what she does at home—sitting in a corner and playing with the same toys over and over." Caregivers are equally frustrated: "We aren't miracle workers here. In the beginning, we tried to include Kaylee in group play, but she just wasn't interested. Her development plan may say 'build social skills,' but, in fact, that works only if Kaylee decides to cooperate. Her parents' expectations of what we're supposed to be able to do are way off base." The director of the child-care program is also frustrated: "I'm between a rock and a hard place. By law, we need to provide care for Kaylee, but I have no budget to train staff in how to work with her. We had her parents do an in-service for us at the beginning of the year but we need more help, period."

Appendix B. For Reflection: Key Qualities in Building Strong Relationships

Brainstorm five key qualities that help staff members build strong, collaborative relationships with families. List them in the first column of the worksheet below. In the second column, jot down one example of how staff members exhibit that skill or attribute in their work. In the last column, brainstorm one example of how you, the supervisor, exhibit that skill or attribute in your interactions with staff members.

Relationship-building Skills	Staff Examples	Supervisory Example
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

References

- Bertacchi, J. (1996). Relationship-based organizations. *Zero to Three*, 17(2), 1, 3-7.
- Brazelton, T. B. (1992). *Touchpoints: Your child's emotional and behavioral development*. Boston: Addison-Wesley.
- Emde, R., Bertacchi, J., & Mann, T. (2001). Organizational environments that support mental health. *Zero to Three*, 22(1), 67-69.
- The Florida State University Center for Prevention and Early Intervention Policy. (2000, September). *Florida's Strategic Plan for Infant Mental Health*. Tallahassee, FL.: FSU Center for Prevention and Early Intervention Policy.
- Greenough, W., Emde, R. N., Gunnar, M., Massinga, R., & Shonkoff, J. P. (2001). The impact of the caregiving environment on young children's development: Different ways of knowing. *Zero to Three*, 21(5), 16-23.
- Greenapan, S. (with Breslau Lewis, N.). (1999). *Building healthy minds: The six experiences that create intelligence and emotional growth in babies and young children*. Cambridge: Perseus Books.
- Greenspan, S. I., & Meisels, S. J. (1996). Toward a new vision for the developmental assessment of infants and young children. In S. J. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 11-49). Washington, DC: ZERO TO THREE.
- Kalyanpur, M., & Harry, B. (1999). *Culture in special education: Building reciprocal family-professional relationships*. Baltimore: Paul H. Brookes.
- Kaplan-Sanoff, M. (2000, April). *Understanding your child's emotional health*. Paper presented at the meeting of Healthy Child Care New England, Brewster, MA.
- Lieberman, A. F. (1993). *The emotional life of the toddler*. New York: The Free Press.
- Meisels, S. J. (1996). Charting the continuum of assessment and intervention. In S. J. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 27-52). Washington, DC: ZERO TO THREE.
- National Research Council and Institute of Medicine (2000). *From neurons to neighborhoods: the science of early childhood development*. J. P. Shonkoff and D. Phillips, (Eds.), Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.
- Ohio Association of Infant Mental Health and the Infant Mental Health Movement, Ohio. (2000). *Five assumptions of infant mental health*. (Available from Bureau of Early Intervention Services, 240 North High Street, Post Office Box 112, Columbus, OH 43266).
- Parlakian, R., & Seibel, N. L. (2001). *Being in charge: Reflective leadership in programs*. Washington, DC: ZERO TO THREE.
- Pawl, J. H. (2000). The interpersonal center of the work that we do. *Zero to Three*, 20(4), 5-7.
- Pawl, J. H., & Dombro, A. L. (2001). *Learning and growing together with families: Partnering with parents to support young children's development*. Washington, DC: ZERO TO THREE.
- Pruett, K. D., M.D. (1999). *Me, myself, and I: how children build their sense of self, 18-36 months*. New York: Goddard Press.
- Segal, M. (1995a). *Your child at play: One to two years*. New York: New Market Press.
- Segal, M. (1995b). *Your child at play: Two to three years*. New York: New Market Press.
- Segal, M. (1995c). *Your child at play: Three to four years*. New York: New Market Press.
- U.S. Department of Health and Human Services. (1996). *Training guides for the Head Start learning community: Promoting mental health*. Alexandria, VA: Head Start Publications Center.
- Weatherston, D. J. (2000). The infant mental health specialist. *Zero to Three*, 20(2), 3-10.
- Wittmer, D., & Franco, P. (2001, January). *Managing Challenging Behaviors in Infants and Toddlers*. Presentation given at the 5th Annual Head Start and Child Care Birth to Three Institute, Washington, DC.
- Zeanah, C. H., & Doyle Zeanah, P. (2001). Towards a definition of infant mental health. *Zero to Three*, 22(1), 13-20.
- ZERO TO THREE Infant Mental Health Task Force. (2001, December). *Definition of infant mental health*. Unpublished manuscript.

Additional Resources

- Emde, R. (2001). A developmental psychiatrist looks at infant mental health challenges for Early Head Start: Understanding context and overcoming avoidance. *Zero to Three*, 22(1), 21-24.
- Gilkerson, L., & Stott, F. (2000). Parent-child relationships in early intervention with infants and toddlers with disabilities and their families. In C. H. Zeanah (Ed.), *Handbook of Infant Mental Health* (pp. 472-484). New York: Guilford.
- Healthy Child Care New England. (2000, April). *Relationships, resiliency, and readiness: Building a system of early care and education mental health services*. Conference Proceedings.. Brewster, MA.
- Lewis, M. L. (2000). The cultural context of infant mental health: The developmental niche of infant-caregiver relationships. In Charles H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (pp. 91-107). New York: Guilford Press.
- Lieberman, A. F. (1997/1998). An infant mental health perspective. *Zero to Three*, 18(3), 3-5.
- Lieberman, A. F., Silverman, R., & Pawl, J. (2000). Infant-parent psychotherapy: Core concepts and current approaches. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 472-484). New York: Guilford.
- Lieberman, A., Wieder, S., & Fenichel, E. (Eds.). (1997). *DC: 0-3 casebook: A guide to the use of ZERO TO THREE's "Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood" in assessment and treatment planning*. Washington, DC: ZERO TO THREE.
- Marsh, J. D. B. (2000, April). *AIMS: Developmental indicators of emotional health. In Relationships, resiliency, and readiness: Building a system of early care and education mental health services*. Proceedings of the conference of

Healthy Child Care New England, Brewster, MA.

Parlakian, R. (2001a). *Look, listen, learn: Reflective supervision and relationship-based work*. Washington, DC: ZERO TO THREE.

Parlakian, R. (2001b). *The power of questions: Building quality relationships with families*. Washington, DC: ZERO TO THREE.

Shirilla, J.J. & Weatherston, D.J. (2002). *Case studies in infant mental health: Risk, resiliency, and relationships*. Washington DC: ZERO TO THREE.

Solchany, J. E., & Barnard, K. E. (2001). Is mom's mind on her baby? Infant mental health in Early Head Start. *Zero to Three*, 22(1), 39-47.

U.S. Public Health Service. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda* (Stock No. 017-024-01659-4). Washington, DC: Author.

Watson, C. (2000, April). Infant mental health services feasibility study. In *Relationships, resiliency, and readiness: Building a system of early care and education mental health services*. Proceedings of the conference of Healthy Child Care New England, Brewster, MA.

Weatherston, D. J. (2001). Relationships for learning: Early Head Start Infant Mental Health in Jackson, Michigan. *Zero to Three*, 22(1), 51-58.

ZERO TO THREE. (1994). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Washington, DC: Author.

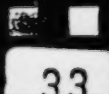
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